

**MEDICARE QUESTIONNAIRE FOR BENEFICIARIES WITH CHILDHOOD DISABILITIES**

NAME <b>THEODORE PUBLIC</b>	DATE OF BIRTH <b>3/5/1974</b>	MEDICARE NUMBER <b>12345678C1</b>
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**INSTRUCTIONS:** This information will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. USE BLACK OR BLUE INK.

EXAMPLE    

	A	B	C						
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1	2	3							
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**SECTION A - INFORMATION ABOUT YOU AND YOUR FAMILY**

1 ) Are **YOU** getting group health coverage through your employment, or a family member's employment?

YES ☒ NO ☐ ( If NO, **STOP**, go to Section B)

2 ) How many employees, including yourself or family member, work for the employer from whom you get group health coverage?

Don't know ☐ 100 or more ☒ Less than 100 ☐ (If less than 100, **STOP**, go to Section B)

Please print the name of the employer, and information about the employer group health plan in the spaces below:

INSURED FAMILY MEMBER'S NAME										Middle		FAMILY MEMBER'S SOCIAL SECURITY NO.									
FIRST										Initial											
J O H N										Q		1 2 3 4 5 6 7 8 9									

LAST										RELATIONSHIP									
P U B L I C										F A T H E R									

EMPLOYER NAME

B R A X T O N   I N C																			
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ADDRESS

1 3 5   M A I N   S T R E E T																			
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CITY										STATE		ZIP							
K A L A M A Z O O										M I		4 9 0 0 6							

NAME OF GROUP HEALTH PLAN

B L U E   H O R I Z O N S																			
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ADDRESS

3 9 0   W E S T   M A I N   S T   S U I T E   4 0 0																			
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ADDRESS

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CITY										STATE		ZIP							
K A L A M A Z O O										M I		4 9 0 1 6							

GROUP IDENTIFICATION NUMBER

1 2 3									
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POLICY NUMBER

1 2 3 4 5 6 7 8 9									
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